REDACTED COPY

Application #: 227837
Date of Issue: ___/___/___

Commonwealth of Massachusetts - Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 - www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

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MAR 3 2006
Board of Registration in Medicine

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)
Bartz	Deborah	Anne	

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____ ☐ Male ☒ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

Entire Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)
Bartz Stein	Deborah	Anne	

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _ _____

Place of Birth: Waukesha (City) Wisconsin (State/Province/Territory) _____ (Country if not USA)

Home Address: _____ (Number and Street) _____ _____

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Business Address: 560 N. [illegible] Avenue Suite G-4 (Number and Street)

Indianapolis (City) [illegible] (State/Province/Territory) 46202 (Zip (or postal) Code)

Business Telephone: (317) 630-6082, ext. _____ Home Telephone: _____

E-mail Address: _____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

Are you applying for licensure through FCVS? (See instructions page 11) ☐ Yes ☒ No

3/21/06
1094
DA

PRINT NAME: Deborah Anne Bartz

Pre-medical School

						From	To
Facility: Macalester College	Degree: B.A.					9/1/94	5/30/98
Street: 1600 Grand Avenue	City: St. Paul			State: MN			
Facility:	Degree:					__/__/__	__/__/__
Street:	City:			State:			

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Board of Registration in Medicine

Medical School

						From	To
Facility: University of Wisconsin-Madison	Degree: MD					8/17/98	5/19/02
Street: 750 Highland Ave	City: Madison			State: WI			
Facility:	Degree:					__/__/__	__/__/__
Street:	City:			State:			

Date of medical school graduation: 5 / 19 / 2002
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

						From	To	
Facility: Indiana University School of Medicine	Position: PGY 1					7/1/02	6/30/03	
Street: 550 N. University Ave. Rm 2440	City: Indianapolis			State: IN				
Facility: Indiana University School of Medicine	Position: PGY 2					7/1/03	6/30/04	
Street: 550 N. University Ave. Rm 2440	City: Indianapolis			State: IN				
Facility: Indiana University School of Medicine	Position: PGY 3					7/1/04	6/30/05	
Street: 550 N. University Ave. Rm 2440	City: Indianapolis			State: IN				
Facility: Indiana University School of Medicine	Position: PGY 4					7/1/05	6/30/06	expected
Street: 550 N. University Ave. Rm 2440	City: Indianapolis			State: IN				
Facility:	Position:					__/__/__	__/__/__	
Street:	City:			State:				

Above dates updated 4/4/06

Deborah Bartz

PRINT NAME: Deborah Anne Bartz

Pre-medical School

Facility: Macalester College Degree: B.A. From 9/1/94 To 5/30/98
Street: 1600 Grand Avenue City: St. Paul State: MN

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Medical School

Facility: University of Wisconsin-Madison Degree: MD From 9/1/98 To 5/30/02
Street: 750 Highland Ave City: Madison State: WI

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Date of medical school graduation: 5 / 19 / 2002
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

From To

Facility: Indiana University School of Medicine Position: Orthopaedic Surgery PGY1 7/1/02 6/30/03
Street: 550 N. University Ave. Rm 2440 City: Indianapolis State: IN

Facility: Indiana University School of Medicine Position: Orthopaedic Surgery PGY2 7/1/03 6/30/04
Street: 550 N. University Ave. Rm 2440 City: Indianapolis State: IN

Facility: Indiana University School of Medicine Position: Orthopaedic Surgery PGY3 7/1/04 6/30/05
Street: 550 N. University Ave. Rm 2440 City: Indianapolis State: IN

Facility: Indiana University School of Medicine Position: Orthopaedic Surgery PGY4 7/1/05 6/30/06 expected
Street: 550 N. University Ave. Rm 2440 City: Indianapolis State: IN

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

PRINT NAME: Deborah Anne Bartz

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: None	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever been licensed: IN
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
3. List Board Certification(s): None Certification date: / /
   Certification date: / /
4. List your practice specialt(ies) OBSTETRICS & GYNECOLOGY
5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: Recently accepted into Fellowship Position with anticipated duration of 2 years
8. Name of Facility: Brigham and Women's Hospital
9. Address: 75 Francis Street City: Boston
10. Anticipated starting date in Massachusetts: 7 / 01 / 06

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

Deborah A. Bartz
Signature of Applicant

2 / 24 / 06
Month Day Year

(Continued on page 4)

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers such as those assigned by health plans, government programs and health care purchasers for the purposes of conducting these business transactions Under the HIPPA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order to complete your license application must take one of the following actions:

Option 1. Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2. Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org

Option 3. Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number you must notify the Board (see instructions for Option 2)

Option 4. Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

☒ My current NPI is: 1 2 9 5 7 0 5 6 5 5

☐ I have personally applied for an NPI.

☐ I have applied for an NPI using a third party (enter name) _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes. (See Lapsed License Instructions, pages 7, 8 and 9). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description) The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	Obstetrics & gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**: This information is required if you authorize BORIM to apply for an NPI on your behalf

Social Security Number:

State of Birth (if US): WI Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan or health organization.

Signature: Deborah A. Barth Date: 2/24/06

PLEASE MAKE A COPY OF ALL PAGES OF YOUR RENEWAL APPLICATION AND ALL ATTACHMENTS BEFORE MAILING YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

SUPPLEMENT FORM

PRINT NAME: Deborah Anne Bartz DATE: 2/24/06

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: Deborah A. Bartz Date: 2/24/06

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: Deborah A. Barth **Date:** 2 / 24 / 06

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Full License Application

Board of Registration

Commonwealth of Massachusetts Board of Registration in Medicine

560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Deborah A. Bartz Date of Birth

Print or Type Name: Bartz (Last name) Deborah (First Name) A (Middle Initial) Social Security No:

Other Name(s) (Please type or print name(s))

Name of Medical School: University of Wisconsin - Madison

Address: 750 Highland Avenue City: Madison State or Province: Wisconsin

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine. we do not handle transcripts!

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below.

Premedical Education: Does your school have a premedical school education requirement? [x] Yes [ ] No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Macalester College

Undergraduate School Address: St Paul MN

(Continued on page 2)

Enrollment and Participation: Our records indicate that

(type or print the applicant's name)	Bartz (Last name)	Deborah (First name)	Anne (Middle initial)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 17 / 98	05 / 16 / 99	07 / 09 / 01	05 / 19 / 2002
	08 / 16 / 99	05 / 21 / 00	/ /	/ /
	07 / 10 / 00	06 / 23 / 01	/ /	/ /

The applicant attended 148 **total weeks or** _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

check one

- [x] was awarded a degree in Medicine on (month/day/year) 05 / 19 / 2002
- [ ] was NOT awarded degree. Please explain reason(s) _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education.

All questions must be answered **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Dixie Drachenberg

Print Name: Dixie Drachenberg

Title: Certification Officer

Date: 03 / 07 / 2006 Telephone: (608) 263-4912

This form will not be accepted unless it is stamped with the institutional seal or notarized.

FULL LICENSE APPLICANT

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810
www.massmedboard.org

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: Deborah A. Bartz Date: 2 / 9 / 06

Print or type name: Deborah A. Bartz

License number: 01057836A Status of license: IN ☒ Active ☐ Inactive ☐ Other _____

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation: _____
2. Date of graduation: ___/___/___ License number: _____ Date of issue: ___/___/___
3. Basis for licensure: _____
   Name(s) of medical licensing examinations(s)
4. Expiration date of license: ___/___/___
5. Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: _____

	YES	NO
7. Has the licensee ever been on probation?	☐	☐
8. Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

Signed: _____

BOARD SEAL

Print Name: _____

Title: _____

State Board: _____ Date: ___/___/___

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.

RECEIVED
FEB 07 2006
Indiana Professional Licensing Agency

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Deborah A. Bartz Date: 2/15/06

Print or Type Name: Deborah Anne Bartz

Name of Institution: Indiana University School of Medicine

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Indiana University School of Medicine, Department OB/Gyn

If name of institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Dr Deb Bartz (Print applicant's name) participated in the following program:

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1-4	OB/GYN	7-1-02	6-30-06	yes in 6/30/06	ACGME

(Continued on page 2)

APPLICANT'S NAME: Deborah Anne Bautz

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☑ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: Excellent Resident

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: Mary Alexandra M.D.

Print Name: Mary Alexandra M.D.

Academic Title: Residency Program Director

Telephone: (312) 630-6082 Today's Date: 2/15/06

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

5/31/09

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810
www.massmedboard.org

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: **If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.**

Liability Carrier: Self-Insured Settlers From: 7/02 To: 6/2006
City: Indpls State: IN Policy Number: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy Number: _____

Applicant's signature: Deborah Bartz ___/___/___
Date

Print Name: Deborah Bartz

Address: _____ City: _____

State: _____ Zip code: _____

More

Additional forms available at the Board's website at www.massmedboard.org

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MALPRACTICE HISTORY

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810
www.massmedboard.org

MALPRACTICE HISTORY

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Waiver for Release of Information

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Applicant's signature: Deborah Bartz 2 / 13 / 06
Date

Print Name: Deborah Bartz

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810
www.massmedboard.org

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: See attached From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: See attached From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Applicant's signature: Deborah Bartz 2 / 13 / 06
Date

Print Name: Deborah Bartz

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

RECEIVED

JUL 10 2006

Board of Registration in Medicine

Massachusetts
Board of Registration in Medicine
Physician Profile

227837
7/12/06

This Profile is not available for public release until 07/06/2006.

DEBORAH A BARTZ MD

I. Physician Information

(The information in sections I - V has been provided by the physician.)

License Status:	Active
License Issue Date:	06/21/2006
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	~~Worksite data being updated~~ Brigham & Women's Hospital
Business Address:	~~550 North University Ave~~ 75 Francis Street ~~Suite 2440~~ Boston, MA 02115 ~~INDIANAPOLIS, IN 46202~~
Phone:	~~(317) 630-6082~~ (617) 732-4806
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospitals:	~~None Reported~~ Brigham & Women's Hospital

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.:** 227837

PART A

1) Current Status: Active **Renewal Due Date:** 10/29/2006 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one). (*See Renewal Instructions, page* 3.)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

2a) MAILING ADDRESS

Division of Women's Health
1620 Tremont St.,OBC 3
Boston, MA 02120

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Division of Women's Health
1620 Tremont St.,OBC 3
Boston, MA 02120

Phone: ~~(617)732-4806~~ error => no change should be same as previous

☒ *Check here to change this address*

Business Address: Same as listed in 2c
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (617) 732-4806

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617-525-7746

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. *(See enclosed instructions and Renewal Instructions, page 4.)*

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Correct?**	**Delete?**
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts:	IN
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*

Principal Work Setting: Change to: Brigham and Women's Hospital

Please enter the *approximate* number of work hours at your principal work setting: 10

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Brigham & Women's Hospital	☐	Associate	Associate	10
	☐			
Women's Health Services	☐	Associate	Associate	4
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: 1 hrs/wk

b) outpatient care 0 hrs/wk Change to: 21 hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

My medical liability insurance is provided through: (check one)

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: Change to: CRICO of Vermont, Inc.

Policy dates: From 7/1/06 To 12/31/06 *(required)*

☐ **Letter of Credit subject to Board approval** ***(attach a copy)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* Yes No

If Yes, please complete Form PCA-O "Office Based Surgery"

In questions 14-21, the phrase "time period" refers to the following: all time from the day you signed your last license renewal/application, to the day you sign this renewal application, inclusive. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered.

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☒ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

PHYSICIAN PROFILE

☒ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

CERTIFICATIONS

1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: Deborah Bartz Date: 10/2/06

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order for your license to be renewed you must take one of the following actions:

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

☒ My current NPI is: 1 2 9 5 7 0 5 6 5 5

☐ I have personally applied for an NPI.

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	obstetrics & gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**: This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (if US): WI Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.

Signature: Deborah Bartz Date: 10/2/06

PLEASE MAKE A COPY OF ALL PAGES OF YOUR RENEWAL APPLICATION AND ALL ATTACHMENTS BEFORE MAILING YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.:** 227837

PART A

1) Current Status: Active **Renewal Due Date:** 10/29/2006 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one). *(See Renewal Instructions, page 3.)*

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

2a) MAILING ADDRESS

Division of Women's Health
1620 Tremont St.,OBC 3
Boston, MA 02120

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Division of Women's Health
1620 Tremont St.,OBC 3
Boston, MA 02120

Phone: ~~(617)732-4806~~ error => no change should be same as previous

☒ *Check here to change this address*

Business Address: Same as listed in 2c.
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (617) 732-4306.

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617-525-7746

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. *(See enclosed instructions and Renewal Instructions, page 4.)*

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Correct?**	**Delete?**
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.:** 227837

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

a) Massachusetts:

b) Federal (DEA):

c) Federal (DEA) XS:

Please make corrections as necessary

8a) Other states where you are now licensed to practice (Abbr.)

IN

8b) States where you were previously licensed (Abbr.)

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*

Principal Work Setting: Change to: Brigham & Women's Hospital

Please enter the *approximate* number of work hours at your principal work setting: 10

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category: Current	Staff Category: Change	*Approximate # Hours per Week*
Brigham & Women's Hospital	☐	Associate	Associate	10
	☐			
Women's Health Services	☐	Associate	Associate	4
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: 1 hrs/wk

b) outpatient care 0 hrs/wk Change to: 21 hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

My medical liability insurance is provided through (check one)

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: Change to: CRICO of Vermont Inc

Policy dates: From 7/1/06 To 12/31/06 *(required)*

☐ **Letter of Credit subject to Board approval** ***(attach a copy)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)* _____

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* Yes No

If Yes, please complete Form PCA-O "Office Based Surgery"

In questions 14-21, the phrase "time period" refers to the following: all time from the day you signed your last license renewal/application, to the day you sign this renewal application, inclusive. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered.

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

c) If you are exempt from CME requirements, check reason for exemption *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☒ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

PHYSICIAN PROFILE

☒ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

CERTIFICATIONS

1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: Deborah Bartz Date: 10 / 2 / 06

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz **License No.: 227837**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order for your license to be renewed you must take one of the following actions:

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES we site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

☒ My current NPI is: 1 2 9 5 7 0 5 6 5 5

☐ I have personally applied for an NPI.

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	obstetrics & gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**. This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (if US): WI Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.

Signature: Deborah Bartz Date: 10/2/06

PLEASE MAKE A COPY OF ALL PAGES OF YOUR RENEWAL APPLICATION AND ALL ATTACHMENTS BEFORE MAILING YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz, M.D. **License No.: 227837**

PART A

1) Current Status: Active **Renewal Due Date:** 10/29/2008 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:
Check only one: (*See Renewal Instructions, page 3.*)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

2a) MAILING ADDRESS
Division of Women's Health
1620 Tremont Street,OBC-3
Boston, MA 02120

☐ *Check here to change this address*

2b) HOME ADDRESS

No mail comes to home address

Phone:

☒ *Check here to change this address*

2c) BUSINESS ADDRESS
Division of Women's Health
1620 Tremont Street,OBC-3
Boston, MA 02120

Phone: (617)525-7744

☐ *Check here to change this address*

3) E-mail Address:

4) Fax Number: 617-525-7746

Please make corrections (print)

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Home Address:
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: _____

Home address cannot be a Post Office Box

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (____)_____

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

5) Specialties (*See Renewal Instructions, page 4.*)	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. (*See enclosed instructions and Renewal Instructions, page 4.*)

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
			☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz, M.D. **License No.: 227837**

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		IN

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Brigham & Women's Hospital	Boston	MA	☐
Planned Parenthood League of MA	Boston	MA	☐
			☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 1 hrs/wk Change to: _____ hrs/wk

b) outpatient care 21 hrs/wk Change to: _____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: Controlled Risk Insurance Company of ~~Vermont, Inc~~ CRICO of Vermont, Inc

Policy dates: From 3 / 3 / 08 To 12 / 31 / 08

Type of Policy: ☒ Claims made with tail coverage ☐ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz, M.D. **License No.: 227837**

In questions 14-21, the phrase "time period" refers to the following -- all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☐ Yes ☒ No

b) If no, are you requesting a CME waiver? ☐ Yes ☒ No

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☒ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Deborah A Bartz, M.D. **License No.: 227837**

PART C

Check One: **PHYSICIAN PROFILE**

☒ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

CERTIFICATIONS

1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.

6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.

8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.

11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq*. I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: Deborah Bartz Date: 9/16/08

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING. YOU MUST RETAIN A COPY OF YOUR APPLICATION FOR YOUR RECORDS, FOR CREDENTIALING AND FOR OTHER PURPOSES.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Deborah A Bartz, M D **License No.:** 227837

Current Status: Active **License Expiration Date:** 11/26/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Division of Women's Health
1620 Tremont Street,OBC-3
Boston
Massachusetts - 02120
United States of America

Home Address:

Business Address:
Division of Women's Health
1620 Tremont Street OBC-3
Boston
Massachusetts - 02120
United States of America
(617) 525-7744

3) **Email Address:**

4) **Fax Number:** (617) 525-7746

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
Indiana

10) **Work Sites**
List of all work sites in Massachusetts including health care facilities (where you are credentialed) private office, clinics, nursing homes etc

WorkSite	Location
Brigham & Women s Hospital Other	Boston

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 1 hrs/wk
b) outpatient care 21 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	06/22/2010	12/31/2010	Occurrence Policy

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending Are there any unresolved malpractice claims against you today, i e , any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine
a) New Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) **Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)** Yes

23) **Do you have a medical condition that interferes in any way or limits your ability to practice medicine?**

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

Physician Name: Deborah A Bartz, M D **License No.:** 227837

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Deborah A Bartz, M.D **License No.:** 227837

Current Status: Active **License Expiration Date:** 11/26/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
1620 Tremont St, OBC-3
Boston
Massachusetts - 02120
United States of America

Home Address:

Business Address:
75 Frances St
Boston
Massachusetts - 02115
United States of America
(617) 732-4806

3) **Email Address:**

4) **Fax Number:** (617) 525-7746

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
Indiana

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed) private office, clinics, nursing homes, etc

WorkSite	Location
Brigham & Women's Hospital	Boston
Other	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 1 hrs/wk
b) outpatient care 21 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2012	12/31/2014	Claims made with tail coverage

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New Have you received notification of a claim, whether or not a lawsuit was filed on that claim or has any medical malpractice claim been made against you during this time period?
b) Pending Are there any unresolved malpractice claims against you today, i e , any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine
a) New Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

Physician Name: Deborah A Bartz, M.D **License No.:** 227837

21)	**Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?**	
22)	**Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)**	Yes

23) **Do you have a medical condition that interferes in any way or limits your ability to practice medicine?**

24) **Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Deborah A Bartz, M D **License No.:** 227837

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M G L c 119 sec 51A and I understand the punishment for failure to comply

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M G L c 19C sec 10 and I understand the punishment for failure to comply

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M G L c 19A sec 15 and I understand the punishment for failure to comply

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M G L c 112 sec 12A and I understand the punishment for failure to comply

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M G L c 112 sec 12A 1/2 and I understand the punishment for failure to comply

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M G L c 112 sec 5F when I have a reasonable basis to believe that a person violated any provisions of M G L c 112 sec 5 or any Board regulation

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M G L c 112 sec 2

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M G L c 62C sec 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M G L c 62E Sec 2

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M G L c 119A

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M G L c 112 sec 5 and 243 CMR 3 00 et seq and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M G L c 112 sec 12AA

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Deborah A Bartz M D **License No.:** 227837

Current Status: Active **License Expiration Date:** 11/26/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
75 Frances St
Boston
Massachusetts - 02115
United States of America
(617) 732-4806

3) **Email Address:**

4) **Fax Number:** (617) 730-2830

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
Indiana

10) **Work Sites**
List of all work sites in Massachusetts including health care facilities (where you are credentialed) private office clinics nursing homes etc

WorkSite	Location
Boston Medical Center	
Brigham & Women's Hospital	Boston

Other

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 1 hrs/wk
b) outpatient care 21 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2014	12/31/2014	Claims made with tail coverage

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i e , any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice, or employer?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility group practice employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) **Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?**

22) **Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)** Yes

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Deborah A Bartz, M D **License No.:** 227837

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M G L c 119 sec 51A and I understand the punishment for failure to comply

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M G L c 19C sec 10 and I understand the punishment for failure to comply

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M G L c 19A sec 15 and I understand the punishment for failure to comply

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M G L c 112 sec 12A and I understand the punishment for failure to comply

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M G L c 112 sec 12A 1/2 and I understand the punishment for failure to comply

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M G L c 112 sec 5F, when I have a reasonable basis to believe that a person violated any provisions of M G L c 112 sec 5 or any Board regulation

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M G L c 112 sec 2

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M G L c 62C sec 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M G L c 62E Sec 2

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M G L c 119A

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M G L c 112 sec 5 and 243 CMR 3 00 et seq and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M G L c 112 sec 12AA

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

CURRICULUM VITAE

NAME: **DEBORAH ANNE BARTZ, MD**
Department of Obstetrics and Gynecology

ADDRESS: Office: Indiana University Hospital
550 University Avenue, Room 2440
Indianapolis, IN 46202
(317) 274-1646

Home:

EMAIL:

DATE OF BIRTH:

PLACE OF BIRTH: Waukesha, WI

CITIZENSHIP: United States

MARITAL STATUS: Married,

LANGUAGE FLUENCY: Spanish, conversational

EDUCATION:

1998-2002	*M.D.*, University of Wisconsin Medical School, Madison, WI 53705
1994-1998	*B.A. in Biology and Spanish*, Cum Laude, Macalester College, St. Paul, MN 55105
1996	Tandem Language Institute, Madrid, Spain

POSTGRADUATE EDUCATION:

2006-2008	*Fellowship*, Family Planning, Obstetrics and Gynecology, Brigham and Women's Hospital, Boston, MA, appointed to start 7/1/2006 through 6/30/2008
2003-present	*Residency*, Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis, IN 46202, expected completion 6/30/2006
2002-2003	*Internship*, Obstetrics and Gynecology, Indiana University School of Medicine, Indianapolis, IN 46202

MEDICAL LICENSE:

Permanent, State of Indiana, #1057836A

AWARDS AND HONORS:

2005	Selected to participate in *ACOG's 2006 Congressional Leadership Conference*, Washington, D.C., March 2006
2005	*Placewinner*, Resident's Day research presentation, Department of Obstetrics and Gynecology, Indiana University School of Medicine
2005	Selected to participate in *ACOG's Residents to Japan Program*, Kyoto, Japan
2004	Selected to participate in *Indiana University-Serbia Resident International Exchange*, Belgrade, Serbia
2002-present	*4.0 Resident Teaching Award*, Indiana School of Medicine
1999	*International Health Exchange Leadership Scholarship*, Cuba
1999	*Trichter Scholarship* for medical service to underserved patients, Bronx, NY
1998	*Henry H. Codden Premedical Award*, Macalester College, St. Paul, MN
1998	*Cum Laude*, Macalester College, St. Paul, MN
1997	*Ganser Fellow* from Academic Affairs Office, Meriter Hospital, Madison, WI

COMMITTEES/ORGANIZATIONS:

Obstetrics and Gynecology Indiana University Residency:

2005-present	*Resident Advisor*, Indiana University OB Student Interest Group
2005-present	*Member*, Student Advisory Committee
2004-present	*Member*, Resident Recruitment Committee
2004-2005	*Member*, Educational Environment Committee
2002-2004	*Member*, 80 Hour Work Week Task Force
2002-present	*Member*, Residency Advisory Committee

Hospital:

2005-present	*Member*, Health Staff Forum
2003-present	*Member*, Riley/IU Newborn Ethics Committee
2003-2004	*Member*, Wishard Hospital Ethics Committee

Regional:

2005	*Physician of the Day*, Indiana State House, Indianapolis, IN

2004-2005	*Indiana Section Junior Fellow Chair*, American College of Obstetrics and Gynecology
2003-2004	*Indiana Section Junior Fellow Vice-Chair*, American College of Obstetrics and Gynecology

Medical School:

1999-2002	*Co-founder*, Public Health Interest Group
1998-2002	*Member*, Medical Students for Choice
1998-2000	*Member*, MEDIC, University of Wisconsin, Madison

PROFESSIONAL SOCIETIES:

American College of Obstetrics and Gynecology
Ob-Gyn's for Women's Health
National Abortion Federation
Indiana State Medical Association
Indianapolis Medical Society

OTHER PUBLIC SERVICE:

2001-2002	*Volunteer*, Planned Parenthood of Wisconsin, Madison, WI
1998	*Volunteer*, Biology Professor Search Committee, Macalester College, St. Paul, MN
1996-1997	*Housing Advocate*, Casa de Esperanza Battered Women's Shelter, St. Paul, MN
1996-1997	*Volunteer*, Clare House AIDS Clinic, St. Paul, MN

RESEARCH INTERESTS:
Contraceptive protocols
Adolescent acceptability of and accessibility to contraception
Cervical dysplasia

RESEARCH EXPERIENCE:

9/2005	*Presenter*, American College of Obstetrics and Gynecology District V Annual District Meeting, Toronto, Canada, Teenage Pregnancy in the United States in Relation to Contraceptive Use. Bartz D., Shew M., Ofner S., Graham M., Fortenberry J.D.
5/2005	*Presenter*, Resident's Day Research Presentation, Department of Obstetrics and Gynecology, Indiana University School of Medicine, The Link Between Adolescent Pregnancy Intentions and Contraceptive

	Behaviors: A daily examination. Bartz D., Shew M., Ofner S., Graham M., Fortenberry J.D. Manuscript in progress.
7/1999	*Presenter*, New York Medical College Research Day, Development of a Behavioral Health Research Tool
4/1998	*Poster Presentation*, Macalester College Annual Biology Poster Presentation, Breaking the Dependence on Emergency Departments: A Case Study of Madison, Wisconsin
5/1997	*Poster presentation*, Macalester College Annual Neuroscience Poster Presentation, The Behavioral effects of Nicotine on Rats with 6-Hydroxydopamine Lesioned Striatal Pathways

TEACHING EXPERIENCE:

Residency

2005	*Lecturer*, Ob/Gyn Intern Orientation, "Effective and Efficient Teaching Strategies in the Ambulatory Setting", Indiana University School of Medicine
2004	*Panelist*, Ethics of Pro-Life vs. Pro-Choice, first and second year medical students' Ethics Course, Indiana University School of Medicine
2002-present	*Lecturer*, Third Year Ob/Gyn Clerkship, Indiana University School of Medicine, "Antepartum Care", "Intrapartum Care", "Preconception Issues: genetics/Teratology", "PIH, Preeclampsia, Eclampsia", "PROM, PTL/PTD", "Puberty and Normal/Abnormal Menses", "Isoimmunization", "Sexual Assault/Domestic Violence and Sexuality", Indiana University School of Medicine

Medical School

1999-2000	*Elementary and High School Speaker*, Doctors Ought to Care, University of Wisconsin, Madison Medical School
1998-2000	*Anatomy lecturer and demonstrator* for undergraduate students, University of Wisconsin, Madison Medical School

Undergraduate

1997-1998	*Neuroscience Class Preceptor*, Macalester College, St. Paul, MN
1995-1997	*Physiology Class Teaching Assistant*, Macalester College, St. Paul, MN